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Investigating Compassion Fatigue in Medical-Surgical Nurses

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Investigating Compassion Fatigue in Medical-Surgical Nurses

by

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A thesis submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
in partial fulfillment of the requirements for the
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Abstract

Medical-surgical nurses are consumed by providing care to patients and families and often forget to care for themselves. Compassion fatigue can lead to lack of caring for one's self in the nurse's life. The purpose of this thesis was to examine the existence of compassion fatigue among medical-surgical nurses and determine the correlation between the range of years of nursing experience and range of age in years. A review of the literature has identified that nurses should practice self-care to combat compassion fatigue. The theoretical framework was based on Jean Watson's Theory of Transpersonal Caring. The Professional Quality of Life (ProQol-5) scale was a 30-question survey used to examine the existence of compassion fatigue among a group of medical-surgical nurses working on two medical-surgical units in an urban acute care hospital. The data collected from the Office 365 forms was analyzed using the Statistical Package for Social Sciences (SPSS 2018) software. There were 30 out of 76 medical-surgical nurses that completed the 30 question ProQOL-5 survey. While compassion fatigue was not identified in the study results, there was an identified moderate level of burnout and secondary traumatic stress with ages 21-30 and two to five years of experience. Although these correlations were not significant, they identified an area of potential concern for leadership.

Keywords: compassion fatigue, compassion satisfaction, burnout, secondary traumatic stress, self-care

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CHAPTER I

Introduction

Nurses make up the largest part of the healthcare arena and are considered caring compassionate professionals. They spend long hours at the bedside providing comfort and attending to the patient's needs. Individuals and families seek nurses for support and encouragement during difficult times of physical, mental, and emotional anguish (Ledoux, 2015). Healthcare organizations today face multiple challenges such as: providing adequate staffing, increased workloads, higher patient acuity, and nursing shortages. According to Ledoux (2015), compassion fatigue was acknowledged by Carla Joinson when she noticed nurses having difficulty dealing with heartache and a loss of the ability to nurture. She believed compassion fatigue caused nurses to experience forgetfulness and exhaustion that often leads to anger (Ledoux, 2015). Nurses cannot give and care for the sick when they are exhausted and worn. The lack of self-care can lead to compassion fatigue in the medical-surgical nurse's life, which can leave the nurses facing difficulties dealing with daily emotions personal and professional (Boyle, 2015).

The purpose of this thesis was to investigate the existence of compassion fatigue in medical-surgical nurses. Compassion fatigue has directly affected many nurses' lives as well as impacting the field of nursing in various ways. Jean Watson's Theory of Human Caring served as the theoretical framework for this thesis.

Significance

Nurses are great at many things, but sometimes taking care of themselves is not one of them (Saavedra, 2016). Nurses are called to provide care for others, often putting their own needs last. The American Nurses Association (ANA) "Code of Ethics" states

that health care workers have a moral obligation to care for themselves so they can care for others effectively (Raines, 2013). The field of nursing as well as nurses' personal lives have been affected by compassion fatigue. Bedside nurses are exposed directly to human suffering, which can over time lead to their own suffering. Once compassion fatigue happens, the nurse is reluctant to connect to the patient, the desire to provide optimal care is no longer there, the nurse is at risk for compromising the kind of care that he/she gives, and becomes satisfied with providing inadequate care. "The results of compassion fatigue are devastating, negatively affecting the nurse, the patient, the organization, and even society" (Ledoux, 2015, p. 2042).

Nurses are faced with many challenges throughout their shift as they provide care to patients and families. Some nurses will skip bathroom and meal breaks to continue to provide care to their patients. Nurse leaders need to promote support and relief to bedside nurses by putting policies and practice standards in to place that provide nurses breaks and allow time to cope with stress.

Purpose

Medical-surgical nurses in acute care settings may be at a greater risk for experiencing emotional distress related to the long hours of direct patient care (Bao & Taliaferro, 2015). Ongoing stressful interactions with patients can initiate compassion fatigue and leave nurses to feel more obligated and less empathetic (Mattioli et al., 2018). The purpose of this thesis was to investigate the existence of compassion fatigue in medical-surgical nurses. This thesis also examined the correlation with range of years in nursing experience and range in years of age with compassion fatigue scores.

Theoretical or Conceptual Framework

Jean Watson's Theory of Human Caring served as the theoretical framework for this thesis. Caring is the cornerstone of nursing. Dr. Jean Watson released a grand theory titled *Theory of Human Caring* in 1979. This theory includes attentiveness to human needs, sensitivity, developing a nurturing relationship of hope and trust, and is considered the fundamental relationship between the nurse and patient. According to Watson (2008), caring can be expressed and practiced by nurses. Caring for patients promotes magnification; a caring environment welcomes a person as they are and considers what they may become. According to Lombardo and Eyre (2011), Watson's theory is grounded in fundamental empathic connection between the nurse and patient and this theory is supportive of relationship-centered nursing. Empathy is at the core of relationship-based nursing and how it is communicated to the patient and family (Lombardo & Eyre, 2011).

Watson's theory focuses on having compassion for patients along with the ability of the caregiver to engage in self-care (Gustin & Wagner, 2012). *Transpersonal Care and the Caritas Theory of Caring* has guided many studies on compassion fatigue and burnout in the past (Hunsaker et al., 2015). Through Watson's *Theory of Human Caring*, connections can easily be made between her theory and the concept of compassion fatigue. The Professional Quality of Life Tool (Pro-QOL 5) survey was used as the tool of measurement for this survey. The (ProQOL-5) survey consists of components related to caring and assisting that may be connected back to the Theory of Human Caring. "Watson's *Theory of Transpersonal Care and the Caritas Processes* provides a framework nurses to foster those human's to human's connection that is so important in

our everyday interpersonal relationships” (Costello & Barron, 2017, pp. 1113-1114).

Figure 1 and Figure 2 illustrate theoretical variables of this research focus on the empirical variables for the research.

Figure 1

Conceptual-Theoretical-Empirical (CTE) Diagram

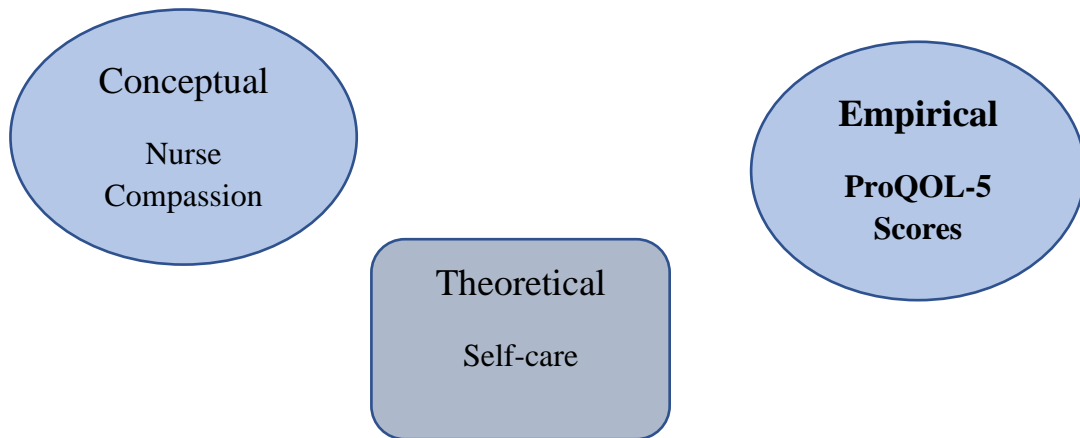
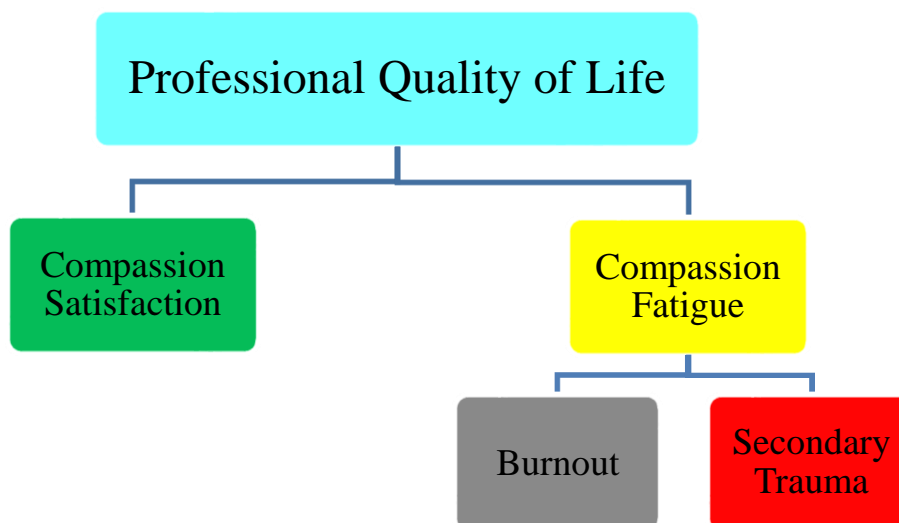


Figure 2

Professional Quality of Life Model (Stamm, 2010).



Thesis Hypothesis

The hypothesis was that compassion fatigue would exist among medical-surgical nurses. Additionally, there would be a correlation that exists between compassion fatigue in medical-surgical nurses with age and years of experience.

Research Questions

This thesis sought to answer the following research questions:

1. Does compassion fatigue exist among medical-surgical nurses?
2. Is there a relationship between age and years of nursing experience with compassion fatigue?

Definition of Terms

- **Compassion Fatigue:** Mental and physical exhaustion that happens over time when providing care to those in need. Diverse understandings and definitions of compassion fatigue persist among various sources. Compassion fatigue can also be conceptualized as emotional, moral, and physical distress, which occurs because of caring and bearing witness to the suffering of others (Crowe, 2016).
- **Compassion Satisfaction:** It is about the pleasure or satisfaction one gains from being able to do their work. There are multiple definitions of what nursing compassion is, and a common definition of nursing compassion is an act to alleviate the suffering of others, and be sympathetic with another's suffering (Ledoux, 2015). Compassion fatigue is defined by Sheppard (2016) as one losing work-related satisfaction or when the job becomes more stressful than bringing satisfaction.

- **Burnout:** It is physical, mental, and emotional exhaustion. It can also lead to detachment and physical symptoms (Sorenson et al., 2016)
- **Secondary Traumatic Stress:** It is the stress resulting from helping or wanting to help a traumatized or suffering person that affects caregivers. It is the stress a caregiver feels after hearing about a traumatizing event a patient has been through (Sorenson et al., 2016).
- **Self-care:** It is an activity that one does in order to take care of mental, emotional, and physical health. In healthcare it is essential to practice self-care in order to provide care to others (Watson, 2008).

Summary

The role of the nurse is vital to providing excellent patient care. Recognizing, managing, and preventing nurse compassion fatigue is a must to ensure healthy nurses and providing quality of care to patients. Nurses juggle dealing with the stress related to patient care, personal life, and the work environment. It takes teamwork between leadership and nurses to create support systems for selfcare and coping mechanisms for compassion fatigue. Nurse leaders and nurses can create an atmosphere that supports and encourages self-care. Working together promotes delivery of high-quality care to patients. The purpose of this thesis was to investigate the existence of compassion fatigue in medical-surgical nurses. This thesis also examined the correlation with range of years in nursing experience and range in years of age with compassion fatigue scores.

CHAPTER II

Literature Review

Nursing is a career filled with complex challenges, yet it is a rewarding profession. Nurses are continuously juggling workloads to meet the needs of patients and families. The obstacles nurses face can be overwhelming, as compassion fatigue leads to acute onset of physical, emotional, and work-related symptoms that affect patient care and relationships (Lombardo & Eyre, 2011). “Compassion fatigue is often conflated with burnout, secondary traumatic stress, and compassion stress” (Sorenson et al., 2016, p. 457). Determining the causes of nurse compassion fatigue could be a key in adapting a self-care plan for prevention and management intervention for nurses. A review of the literature helped gain an understanding of nursing compassion fatigue and an appreciation for research that has been completed on this specific topic. It also revealed the need for further research on compassion fatigue in medical-surgical nurses. The purpose of this thesis was to investigate the existence of compassion fatigue in medical-surgical nurses. This thesis also examined the correlation with range of years in nursing experience and range in years of age with compassion fatigue scores.

Review of Literature

A web-based search was performed using CINAHL, EBSCO, Medline, AHEC, PubMed, and Google Scholar databases. The following key words were utilized as search criteria: compassion fatigue, compassion satisfaction, burnout, secondary traumatic stress, and self-care. The resources reviewed were peer-reviewed journals, articles, and reports from reputable websites. Results were limited to years 2007-2019, resulting in a 12-year time frame.

Nurse Compassion Fatigue

Compassion fatigue in nursing can be the cumulative effect of the strong, genuine, empathetic feelings experienced by nurses while providing emotional support and medical care to patients and families (Mennella, 2018). Nurses may experience increased compassion fatigue due to higher patient acuity, increased workload, secondary traumatic stress disorder, and witnessing pain and suffering (Mennella, 2018). Advocating and collaborating with colleagues in administration to ensure programs are available with policy support to address optimal strategies for nurse compassion fatigue (Mennella, 2018).

Nursing burnout and compassion fatigue have been identified as significant issues for nurses within the healthcare setting. Compassion fatigue is happening not only in emergency workers but is also in nurses that work in small and large hospitals (Yoder, 2010). A study completed by Yoder (2010) identified that nurses are unconsciously aware of their risk for compassion fatigue; it can affect the quality of work and individual life of the nurses and other healthcare staff (Smart et al., 2013). The study used both quantitative and qualitative design, and the ProQol-5 survey results revealed compassion fatigue in emergency room and medical-surgical nurses. Another interesting result is the identified triggers that included caring for patients with deteriorating conditions and the nurse feeling as if nothing they do can change the situation. The nurses that completed the narrative portion of the study gave examples that triggered compassion fatigue and burnout such as: demanding patients that are never satisfied, families that are unrealistic when a loved one is dying, and system issues such as high acuity, personal issues, etc. Without positive interventions, compassion fatigue can cause lasting changes to a nurse's

ability to demonstrate compassion (Smart et al., 2013). Organizations willing to support programs to reduce compassion fatigue have the opportunity for improvement in financial savings by decreasing turnover and adverse events related to compassion fatigue (Kelly et al., 2015).

Inadequate care to patients can be influenced by nurses that are experiencing burnout and compassion fatigue (Abbaszadeh et al., 2017). A study investigating the relationship between compassion fatigue and burnout among 191 nurses working in a variety of settings to include intensive care unit, surgery, and emergency departments was conducted (Abbaszadeh et al., 2017). The demographics included a mean age of 35 years, and a mean year of service of 11 years (Abbaszadeh et al., 2017). Other demographics collected noted 71% female nurses, 29% male nurses, and 71% nurses were married, and 29% nurses were single (Abbaszadeh et al., 2017). The study used Figley compassion fatigue questionnaire and Maslach Burnout Inventory for burnout scores (Abbaszadeh et al., 2017). The research data was analyzed using SPSS 20 software, and the results reported defined no significant relationship between compassion fatigue and burnout in the nurses working in the selected area (Abbaszadeh et al., 2017). However, the study did show the nurses working in the emergency department were at a higher risk for compassion fatigue and burnout than the nurses working in intensive care and surgery (Abbaszadeh et al., 2017). A trending factor revealed in this study also suggested that the years of experience and age defines lower compassion fatigue, and it is thought to be related to the years of experience providing the ability to deal with the work stressors (Abbaszadeh et al., 2017).

Nurse compassion fatigue is often considered to be the cost endured by nurses for caring, coming from their exposure of numerous interactions of caring for patients in distress that necessitate increased amounts of care (Sorenson et al., 2016). A literature search using terms related to compassion fatigue was conducted to provide a narrative view. The purpose of the literature search was to analyze existing literature regarding compassion fatigue with close attention to practice area and healthcare worker role (Sorenson et al., 2016). The literature search resulted in 307 articles, of which 43 articles met the inclusion criteria (Sorenson et al., 2016). Three studies that looked at a mixed professional staff in hospice care found that improved self-care decreases compassion fatigue and increases compassion satisfaction (Sorenson et al., 2016). Emergency department nurses were identified as high risk for compassion fatigue and reported symptoms of secondary traumatic stress (STS), with 33% of nurses meeting all the criteria listed for STS (Sorenson et al., 2016). An interesting finding was that despite these high scores for compassion fatigue, these same nurses reported high compassion satisfaction (Sorenson et al., 2016). The most significant preventative measure nurses can use to decrease the chance of developing compassion fatigue is practicing self-care interventions (Sorenson et al., 2016). Other identified measures for prevention of compassion fatigue were educational programs, leadership developing strategies for better teamwork, and positive work environment (Sorenson et al., 2016).

According to Henson (2017) several studies show unhealthy work environment and insufficient leadership are identified reasons for compassion fatigue. Nurse leaders' actions and attitudes have a great impact on how productive and negative the work atmosphere is perceived (Henson, 2017). Compassion fatigue studies among intensive

care, hospice, emergency, and general medical units using the ProQOL-5 survey identified high levels of compassion fatigue (Henson, 2017). The identified signs of compassion fatigue were listed in three categories: emotional effects, physical effects, and spiritual effects. The emotional effects on nurses consisted of stress, anxiety, nightmares, exhaustion, and depression (Henson, 2017). The most reported physical effect was loss of sleep, while moral distress and decreased spiritual well-being was the most reported for spiritual effects (Henson, 2017). Other findings influencing compassion fatigue included environmental factors such as poor staffing, increased workloads, unexpected death, poor patient outcomes, and lack of leader support (Henson, 2017). Work environments that have strong leadership with meaningful recognition and nurse engagement have higher levels of compassion satisfaction and lower levels of compassion fatigue (Henson, 2017).

Providing nursing care in the acute care, medical setting to sick and dying patients is both emotionally and physically demanding, which makes these nurses more susceptible to developing compassion fatigue (Upton, 2018). Environmental and psychosocial factors were found by Upton (2018) to affect the levels and prevalence of compassion fatigue among hospital nursing staff working in an acute medical care setting. The mixed-methods study by Upton (2018) used a work-related/demographic survey, the Self-Compassion Scale, and the Traumatic Stress Scale to measure compassion fatigue to explore environmental and psychosocial factors affecting compassion fatigue among the nursing staff. A one-way ANOVA was performed to examine demographic and work-related characteristics of self-compassion and compassion fatigue, and the Pearson correlation co-efficient explored the relationship

between self-compassion and compassion fatigue. Multiple regression was then used to determine if there was a predictive relationship between self-compassion and compassion fatigue. Recorded interviews conducted as part of the Self-Compassion Scale were transcribed verbatim and investigated using thematic analysis.

Upton (2018) found compassion fatigue to be prevalent among nurses working in the acute medical care setting, along with its damaging effects. Self-compassion was also confirmed to have a moderate effect on compassion fatigue and identified as having the ability to predict compassion fatigue. The most commonly reported symptoms of individuals included discouragement about the future, intrusive thoughts, along with irritability, difficulty sleeping, and hypervigilance. Thematic analysis identified four, inter-related, significant themes: behavioral effects, cognitive effects, emotional effects, and physical effects. Factors identified through thematic analysis as contributing to compassion fatigue development were environmental factors, external factors, hospital organizational factors, patient factors, self-factors, and ward management factors. Self-factors included individual nurse conflict with how they wanted the care they provide to be with their ability to achieve their ideal standards, the feeling that care that is genuine and authentic was not supported, and stress due to only meeting basic care needs because of the patient workload.

Other contributing factors to their experience of compassion fatigue causing stress was lack of managerial support, which included failure to address other staff providing unsatisfactory patient care (Upton, 2018). Acute care medical center organizational factors that were voiced by participants included the notorious frenzy in a general acute care medical environment where there are staff shortages, staff retention issues, the nurse

skill mix was poor, and the nurses were caring for patients with multiple, complex needs. All these factors negatively impacted the workload situation. Inappropriate and threatening patient behavior was also said to diminish a nurse's ability to foster a caring, compassionate relationship with the patient. Environmental factors included the physical working environment and the positioning of the nurse break room, allowing various health care professional to interrupt their break time.

According to Upton (2018), to improve levels of self-compassion in nurses, the predominant change needs to occur with managerial behavior and attitude. Upton (2018) advocates that the people of most influence in the system need to actively engage in demonstrating their commitment to values and behaviors that support caring and that compassionate environments would allow nurses a greater opportunity to demonstrate compassionate, authentic, patient care that is an expectation of their caring profession.

Workload

The heavy workload of inpatient hospital nurses is a significant problem for the United States health care system (Carayon & Gurses, 2008). A better understanding of what the term "nursing workload" means was needed, as it is not always clearly defined in the literature. The study used a concept analysis utilizing Walker and Avant's method in defining attributes related to nursing workloads (Alghamdi, 2016). Only one data base was searched and articles that did not include 'workload' in the title or abstract were excluded from the study (Alghamdi, 2016). The data base CINAHL produced 221 articles, and 32 articles met the criteria to used in the study. This review of the literature allowed a closer look at all the aspects of direct and indirect contributions that nurses gives towards providing care to a patient. "Nursing workload is the amount of time and

care that a nurse can devote (directly and indirectly) towards patients, workplace, and professional development” (Alghamdi, 2016, p. 455).

The nature of nursing work across different hospital settings impact the quality and level of care provided to the patient (Alghamdi, 2016). According to Alghamdi (2016), nursing workload falls into five categories: the amount of nursing time, the level of competency, the amount of direct patient care, the amount of physical exertion, and complexity of care (Alghamdi, 2016). There are potential consequences to increased nurse workloads such as, greater risks of adverse effects with patient safety, decreased job satisfaction, high turnover rates, and burnout (Alghamdi, 2016). Heavy nursing workloads directly influence a nurse’s ability to assess thoroughly and promote the best patient outcome (Alghamdi, 2016). Determining how nurse workload impacts nurse compassion fatigue could be a key to identifying interventions to change the nurse work environment. Many states have started to or are considering minimum staffing ratios to decrease nursing workloads (Upenieks et al., 2007). California hospitals was the first to mandate nurse-to-patient ratios (Upenieks et al., 2007).

Healthcare organizations and human resources have the duty to accurately assess nurse workload to promote patient safety, meet national standards of patient care, and protect nurses from injury and burnout (Mennella & Karakashian, 2018). Work overload is frequently reported by nurses and is often a mentioned motivator for job change and contributor to burnout and emotional exhaustion (Bogaert et al., 2013). A cross-sectional survey utilized acute care registered nurses at two hospital settings (Bogaert et al., 2013). The data was collected by nursing work index survey, burnout was measured using Maslach Burnout Inventory Human Service survey, and demographic information such as

age, gender, years in nursing, work schedule, qualifications, and years on current unit (Bogaert et al., 2013). The total study participants were 1,201 nurses, with 85.2% female and held a baccalaureate degree (Bogaert et al., 2013). Significant results defined 40% indicated hospital quality of care had deteriorated, 34% had scores that were high or very high with burnout and emotional exhaustion (Bogaert et al., 2013). This study indicated that nursing workload can have a profound effect on nurses with burnout and emotional exhaustion.

Patient Acuity

Nurses are faced with complex patient admissions with higher acuity levels than in the past (Al-Dwek & Ahmed, 2019). These patients required more of the nurse's time. Higher patient acuity and increased patient admissions in recent years has placed a growing need for more nurses and has added more stress with managing patient care. Optimal staffing is related to clinical and institutional excellence (O'Keeffe, 2016). Healthcare organizations will face difficulty dismissing current systems of census and opinion lead staffing toward an acuity driven measure of staffing (O'Keeffe, 2016). Nurse leaders need to engage in moving away from point of view or opinion-based acuity patient assignments and engage staff nurses to give input with new processes (O'Keeffe, 2016).

Some hospitals have standardized acuity tools for units to use, while other hospitals rely on the charge nurses' assessment of patient acuity (Kidd et al., 2014). A progressive care unit reported scores of increased nurse satisfaction after implementing a new patient-acuity assignment tool (Kidd et al., 2014). According to Kidd et al. (2014), most nurses expect patient assignments to be equitable, with a fair share of workload to

provide excellent care to all patients. It is a difficult task to know exactly how to schedule nurse to patient ratios in a busy inpatient unit (Al-Dwek & Ahmed, 2019). The traditional way of assigning nurses for providing optimal patient care is the nurse to patient ratio (Kidd et al., 2014). A progressive care nursing unit approached the unit-based council with the idea of adapting an acuity tool that provide more equitable patient assignments (Kidd et al., 2014). The literature review supported that nurses added the most valuable contributions by assessing their own workloads, staffing resources, and should be involved in the design of an acuity tool (Kidd et al., 2014). The literature review revealed positive outcomes with nurse driven acuity tools with improved nurse satisfaction (Kidd et al., 2014). The acuity tool designed by the progressive care unit showed a marked improvement in the nurses' reports of fairer patient assignments (Kidd et al., 2014). At the end of the month the acuity was 55% of nurses favored more equitable patient assignments, and 89% nurses favored consistency with new acuity assessment tool (Kidd et al., 2014). Providing lower nurse-to-patient ratios can be associated with higher adverse incidents (Liang & Turkcan, 2016).

Historically, patient acuity was the organizing framework to designing the allocation of hospital beds and scheduling of nursing staff (Kitchens et al., 2018). The inpatient hospital environment is faced with changes driven by technology, funding, and engineering advances (Kitchens et al., 2018). Balancing nursing workloads would allow for better allocation of staff to provide the best quality of care to patients (Chiulli et al., 2014).

Identifying Compassion Fatigue

The symptoms of compassion fatigue have the potential to destroy careers, disrupt lives, and must be recognized and treated with respect (Showalter, 2010). Understanding that compassion fatigue can develop, and early recognition of signs and symptoms can aid in early intervention or prevention. Compassion fatigue often develops from a combination of things such as workload, patient acuity, working too many hours, and lack of self-care. According to Mennella (2018) signs and symptoms of compassion fatigue can occur suddenly or overtime, and the severity may vary affecting the healthcare worker's emotional, mental, physical, and psychological status. The signs and symptoms of compassion fatigue can include the following: avoidance of certain patients, anxiety, stress, anger, emotional outbursts, and dissociation (Mennella, 2018). Physical signs of compassion fatigue can be sleep disturbances, increased work absenteeism, nausea, headaches, and muscle tension (Mennella, 2018).

Self-Care

Maintaining a balance in lives that are so intense with patients, professional, and family demands is never easy. "To restore the balance and work in harmony, one must first acknowledge their own personal needs" (Showalter, 2010, p. 240). Self-care is an important strategy to prevent compassion fatigue by getting enough rest, having quiet time daily, exercise, healthy diet, and having interests outside of work (Showalter, 2010). According to Kiss (2017) nurses should "be accountable for maintaining their own mental and physical health" (p. 8). The most reported preventable measure for compassion fatigue prevention is self-care (Sorenson et al., 2016).

Leadership ensuring compassion fatigue education is provided to medical-surgical nurses is vital to the stability of organizations. According to Showalter (2010) the costs associated with compassion fatigue are many: staff turnover, decreased productivity, low morale, and more. Healthcare workers may not identify what they are experiencing as compassion fatigue. The long-worked hours being exposed to suffering for months can wear on a nurse's well-being (Boyle, 2015). Knowledge is power. To win against compassion fatigue, nurses must have available resources and practice self-care strategies (Boyle, 2015).

Summary

Compassion fatigue is prevalent across the healthcare system, and early acknowledgement of its existence can lead to prevention and management of the problem. Nurses are under constant stress meeting the demands of patients, families, workload, and self that they become so exhausted that they are no longer able to provide care for others or themselves. Nurses that are fully engaged their work are usually energetic and feel satisfied from providing quality patient care. Compassion fatigue can significantly impair a nurse's job performance. Multiple studies showed nurse compassion fatigue causes physical, emotional, and self-care deficits for the affected nurse. Compassion fatigue is prevalent and preventable and early recognition of can lead to quicker interventions. It is pertinent that nurse leaders and current nurses in all aspects of healthcare are aware of the signs and symptoms of compassion fatigue and are provided with resources to promote self-care and early management. Hospitals that promote self-care for nurses with compassion fatigue may benefit by improved nurse retention.

CHAPTER III

Methodology

Nurses working in the medical-surgical acute care setting provide care to the sick and dying patients, which can be emotionally and physically demanding. Nurses working in the medical-surgical units can be at risk for compassion fatigue. The purpose of this thesis was to investigate the existence of compassion fatigue in medical-surgical nurses. This thesis also examined the correlation with range of years in nursing experience and range in years of age with compassion fatigue scores. The intention of this research was to gain information that may be useful for leadership in preventing compassion fatigue, promoting self-care, and managing nurse compassion fatigue.

Study Design

This study utilized a descriptive quantitative design. The participants completed the Professional Quality of Life Scale (ProQOL-5), giving a score for each subscale compassion satisfaction, burnout, and secondary traumatic stress. These symptoms develop as medical-surgical nurses have prolonged exposure to patients suffering. The three subscale scores were then compared to determine any relationship between the variables. The participant's range of years of experience and range of years in age were compared to the ProQOL-5 survey results to determine the correlation with compassion fatigue.

Setting and Sample

The setting for this study was in an urban acute care hospital on two selected medical-surgical units. All registered nurses (RN's) working at the bedside in the medical-surgical units were invited via email to take the survey. The purpose of this

thesis was to investigate the existence of compassion fatigue in medical-surgical nurses. This thesis also examined the correlation with range of years in nursing experience and range in years of age with compassion fatigue scores. The intention of this thesis was to identify the existence of compassion fatigue in medical-surgical nurses because previous studies have evaluated compassion fatigue in oncology nurses, emergency room, and critical care nurses (Abbaszadeh et al., 2017).

Measurement Methods

Participants were given the Professional Quality of Life (ProQOL-5) scale survey tool used for measurement (see Appendix A). The researcher received permission to use the (ProQOL-5) survey via online request (see Appendix B). This tool can be used by anyone for research and educational purposes. The (ProQOL-5) survey contained 30 questions related to three subscales, compassion satisfaction, burnout, and secondary traumatic stress. The questions were answered by the participants using a Likert-Scale: 1=never, 2=Rarely, 3=Sometimes, 4= Often, and 5=Very Often. This scale provided the participants scores in compassion satisfaction, burnout, and secondary traumatic stress. These scores were then compared to any correlation with range in years of nursing experience and range in years of age.

The three subscales used to measure Pro-QOL-5 survey results measured compassion fatigue and compassion satisfaction (Stamm, 2010). Reliability and validity of the ProQOL-5 tool has been previously established, and it is used to measure attribute of caring and compassion fatigue among nurses and other healthcare workers (Hooper et al., 2010). The ProQOL-5 has been used in "...over two-hundred published papers"

(Stamm, 2010 p. 13). There are many studies that have been completed related to nursing compassion fatigue.

Data Collection Procedures

The participants completed the ProQOL-5 survey scale online through Office 365 Forms. The survey was provided to participants via work e-mail containing a link to Office 365 Forms. The e-mail included informed consent (see Appendix C), which included an explanation of the purpose of the study, the potential risks, and benefits associated with the survey, and the survey was available to all participants at any time during the open survey time line of ten days, ending on a Friday at 1400 hours (see Appendix D).

Protection of Human Subjects

Prior to the beginning of the survey, the researcher obtained approval from the University's Institutional Review Board (IRB) and IRB of the hospital utilized in the study. The survey was offered via e-mail providing a link to Office 365 forms to volunteer participants. The survey posed minimal risk and all answers were anonymous. The data was collected and stored on a password protected computer and the results were only available to the researcher. Participants were provided informed consent prior to beginning the survey and implied consent to participate after clicking the link. Participants had the right to not participate in the survey.

Data Analysis

The researcher downloaded collected data from Microsoft 360 Forms onto an Excel Spreadsheet. The Compassion Satisfaction, Compassion Fatigue, and burnout scales were scored using the prescribed recoding in the ProQOL-5 Manual. Data was then

uploaded and analyzed using IBM SPSS Statistics Subscription. Cronbach α was used to examine the internal consistency reliability of the ProQOL-5 scale in the sample.

Kendall's Tau-B correlation tests were performed to describe the correlations between each of the three ProQOL-5 subscales. Pearson chi-square tests were performed to understand the effect that age and years of experience have on Compassion Satisfaction and Compassion Fatigue (Burnout and Secondary Traumatic Stress).

CHAPTER IV

Results

The purpose of this thesis was to investigate the existence of compassion fatigue in medical-surgical nurses. This thesis also examined the correlation with range of years in nursing experience and range in years of age with compassion fatigue scores. This chapter presents the data analysis that supports nonexistence of compassion fatigue among medical-surgical nurses and show correlations with the range in years of nursing experience and range in age of years.

Sample Characteristics

The sample included 76 available medical-surgical nurses working in two selected medical-surgical units in an urban acute care hospital and 30 total surveys were completed. There were no disqualified surveys, as all were completed. The total of 30 surveys were used for data analysis which reflected a 39% participation rate. Demographic characteristics chosen for the purpose of this study are presented in Table 1. The majority of the sample were between the ages 21-30 and 31-50 (36.6%, 36.7%), and had greater than 10 years of experience (36.7%).

Table 1*Descriptive Years of Experience and Age*

	Frequency	Percent (%)
Age		
21-30	11	36.6
31-50	11	36.7
Greater than 50	8	26.7
Years of Experience		
Less than 2	4	13.3
2-5	9	30
6-10	6	20
Greater than 10	11	36.7
Total	30	100

Note: (n=30)

Scores for compassion satisfaction (CS), burnout (BO), and secondary traumatic stress (STS) were calculated for each survey response. BO and STS served as subcategories for compassion fatigue (CF). In the ProQOL-5 survey, CS scores below 23 showed negative satisfaction for one's job. While BO and STS scores above 41 show positive compassion fatigue. The average score for compassion satisfaction was 40.23, burnout was 23.40, and secondary traumatic stress was 22.86. Out of the 90 responses, 30 resulted in moderate to high compassion satisfaction, 30 resulted in low to moderate burnout, and 30 resulted in low to moderate secondary traumatic stress. Frequency of CS, BO, and STS responses are portrayed in Table 2.

Table 1*Frequency of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress*

Characteristic	Low	Moderate	High
Compassion Satisfaction	0	14	16
Burnout	16	14	0
Secondary Traumatic Stress	13	17	0

Note: (n=30)

Standard Cronbach α values for the three subscales of the ProQOL-5 instrument is 0.88 for CS, 0.75 for BO, and 0.81 for STS. Calculated Cronbach α values, using the survey responses, were 0.94 for compassion satisfaction, 0.85 for secondary traumatic stress, and 0.93 for burnout. Overall, participants scored within the average range for all three PROQOL-5 subscales; with group and individual findings in the CS and CF measures being consistent throughout.

Major Findings

Kendall's tau-b was used to determine the correlation between age and years of experience as a registered nurse, with compassion satisfaction (CS), burnout (BO), and secondary traumatic stress (STS). The results quantify the underlying assumption that age and years of experience contribute to compassion fatigue.

There was no statistically significant correlation found between age and CS ($\tau_b=0.139$, $p=0.348$); BO ($\tau_b=-0.140$, $p=0.348$); or STS ($\tau_b=-0.175$, $p=0.242$). Kendall's tau-b in this study, however, showed a positive correlation with CS and age, but a negative correlation with BO and STS and age (Table 3).

Table 2

Correlations of Age to Compassion Satisfaction and Compassion Fatigue

Measure	Age	P-value
Compassion Satisfaction	0.139	0.348
Burnout	-0.140	0.348
STS	-0.175	0.242

There was no statistically significant correlation found between years of experience and CS ($\tau_b=0.240$, $p=0.098$); BO ($\tau_b=-0.109$, $p=0.452$); or STS ($\tau_b=-0.124$,

$p=0.397$). Kendall's tau-b showed a positive correlation with CS and years of experience, but a negative correlation with BO and STS and years of experience (Table 4).

Table 3

Correlations of Years of Experience to Compassion Satisfaction and Compassion Fatigue

Measure	Years of Experience	P-value
Compassion Satisfaction	0.240	0.098
Burnout	-0.109	0.452
STS	-0.124	0.397

Compassion Satisfaction had a statistically significant negative correlation in how it related to burnout ($\tau_b=-0.491$, $p=0.01$) and secondary traumatic stress ($\tau_b=-0.493$, $p=0.01$). A statistically significant positive correlation was found between burnout and secondary traumatic stress ($\tau_b=0.651$, $p=0.01$) (Table 5).

Table 4

Correlations of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress

Measure	CS	BO	STS
Compassion Satisfaction (CS)	-	-0.491	-0.493
Burnout (BO)	-0.491	-	0.651
Secondary Traumatic Stress (STS)	-0.493	0.651	-

Note: 1 $p < 0.01$, two-tailed

Analysis presented in Table 6 indicates that levels of the three subscales were not significantly different across age and years of experience, based on Pearson's Chi-Squared statistics.

Table 5

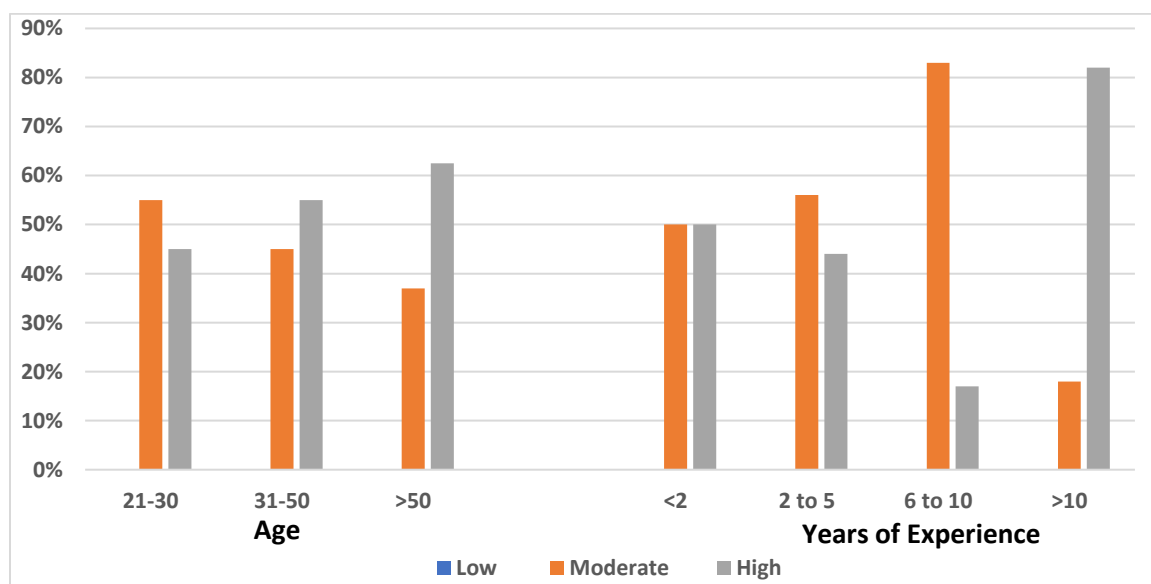
χ^2 Test Comparing Age and Years of Experience to Compassion Satisfaction and Compassion Fatigue

Measure	Compassion Satisfaction		Burnout		Secondary Traumatic Stress	
	χ^2	p	χ^2	p	χ^2	p
Age	0.551	0.759	2.788	.248	4.640	0.98
Years of Experience	7.131	0.068	3.153	0.369	2.378	0.498

Figure 3 portrays how there is no statistical difference in age or years of experience and compassion satisfaction. The graph denotes differences in levels of compassion satisfaction with 6-10 and greater than 10 years of experience, but all nurses responded with moderate or high compassion satisfaction levels.

Figure 3

Levels of Compassion Satisfaction (CS) According to χ^2 Test

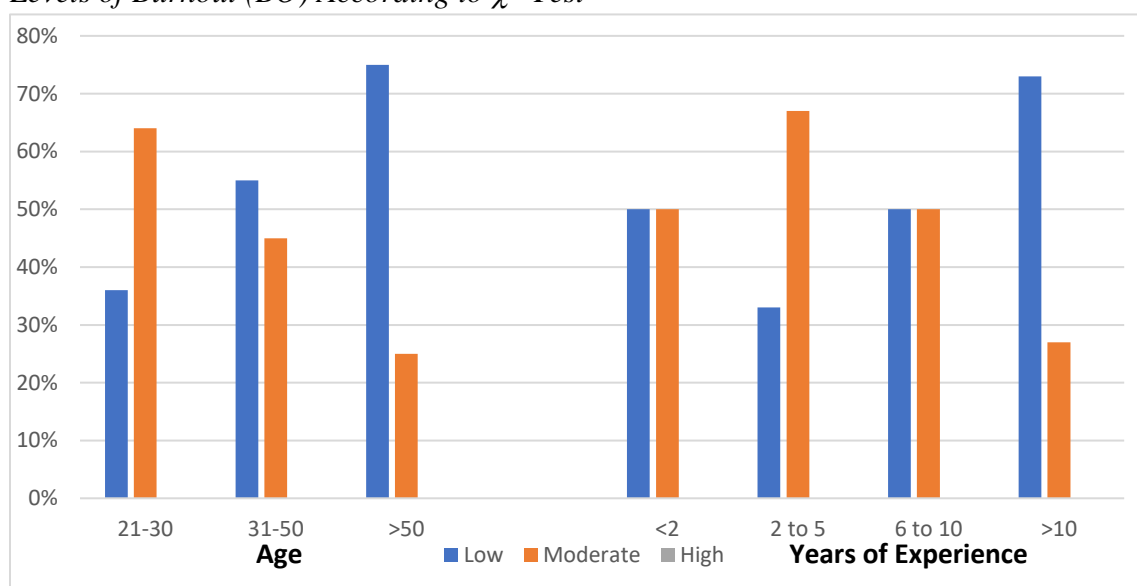


Note: low= 22 or less; moderate= 23-41; high = 42 or more

Figure 4 depicts the relationships between age and years of experience with levels of burnout. The graph denotes nurses greater than 50 years old and with more than 10 years of experience reported low levels of burnout. Overall, all nurses reported low to moderate levels of burnout and there is no significant difference.

Figure 4

Levels of Burnout (BO) According to χ^2 Test

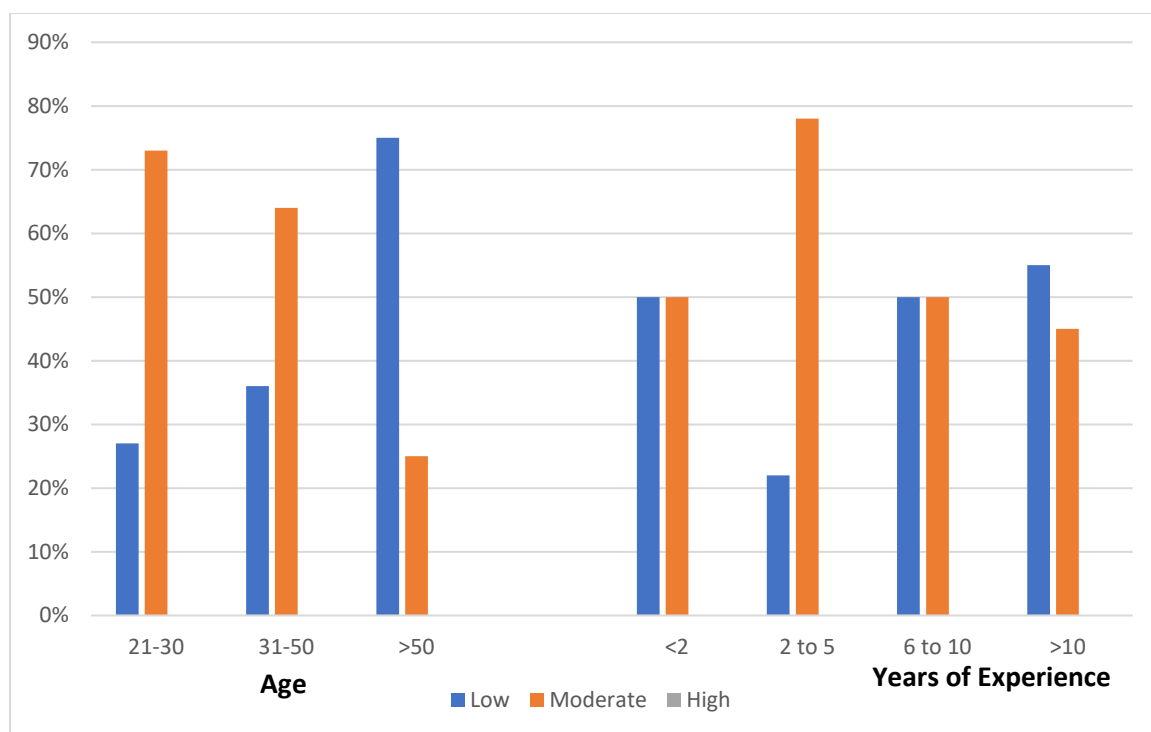


Note: low= 22 or less; moderate= 23-41; high = 42 or more

Figure 5 shows the relationship between age and years of experience with levels of secondary traumatic stress. The graph denotes nurses ages 21-30 have more moderate STS while nurses over 50 have low STS. Further, nurses with two to five years of experience have moderate STS.

Figure 5

Levels of Secondary Traumatic Stress (STS) According to χ^2 Test



Note: low= 22 or less; moderate= 23-41; high = 42 or more

Summary

As shown through statistical analysis, compassion fatigue does not exist in medical-surgical nurses. There is no relationship between age and years of experience with compassion fatigue. Compared to the averages in the existing literature which use the ProQOL-5, medical-surgical nurses in this study had moderate levels of compassion satisfaction (mean= 40.23, with top quartile= 42), and moderate levels of compassion fatigue (secondary traumatic stress mean= 22.8, burnout mean= 23.4, with mid-point= 22). Years of experience and age had no significant correlation to compassion satisfaction or compassion fatigue. With high homogeneity, there is no significant difference shown by the Pearson's Chi-Squared test.

CHAPTER V

Discussion

As medical-surgical nurses provide care for patients, they experience and witness many different emotions. Medical-surgical nurses can be consumed in providing care to patients and families. Compassion fatigue can be experienced by medical-surgical nurses by not taking care of themselves. The purpose of this thesis was to investigate the existence of compassion fatigue in medical-surgical nurses. This thesis also examined the correlation with range of years in nursing experience and range in years of age with compassion fatigue scores.

Implication of Findings

The study was aimed to identify the existence of compassion fatigue among medical-surgical nurses. Previous research has identified compassion fatigue in oncology nurses, emergency room, and critical care nurses (Abbaszadeh et al., 2017). The existence of compassion fatigue in medical-surgical nurses was not identified through this study. There was an identification of moderate burnout and secondary traumatic stress with medical-surgical nurses with two to five years nurses experience, which is 30% of the sample of medical-surgical nurses that completed the survey. This represents a potential for medical-surgical nurses to develop compassion fatigue. Overall, participants scored within the average range for all three ProQOL-5 subscales with group and individual findings in the compassion satisfaction and compassion fatigue measures being consistent throughout the study. A positive correlation was identified with the years of nursing experience and compassion satisfaction. As the years increased, the compassion satisfaction increased

Application to Theoretical/Conceptual Framework

Jean Watson's theory provided guidance for overcoming compassion fatigue. In order for a nurse to be able to provide care to a patient, the nurse must first be able to care for one's self. Self-care practices for nurses are a must to ensure the complete ability to provide care. Nurse's may apply Watson's *Caritas* processes as a way of preventing or dealing with their own compassion fatigue. The ProQOL-5 tool used in this survey has specific question to define levels of helping and caring, which can be connected to the fundamental basis of *Watson's Theory of Caring*. Watson's concepts can be aligned to promote self-care of the nurse, improve compassion fatigue, and improve care of the patient. Leadership members within healthcare organizations should focus on initiating Watson's *Caritas* processes to recognize and prevent compassion fatigue.

Limitations

A major strength in this study was the range of nurse age and years of experience. The use of a previously validated questionnaire (Pro-QOL 5) is also a strength. However, due to a small sample, it is a possibility that a significant difference is not shown in the data. With a larger sample size, there could be enough data to eliminate the "moderate" responses to compassion levels. A potential limitation of this study was the potential for travel nurses possibly completing the survey, which would narrow the characteristics of the sample.

Implications for Nursing

Healthcare organizations should acknowledge that compassion fatigue is a potential problem and provide a supportive network for all nurses. Nurses also need to develop self-awareness of compassion satisfaction, compassion fatigue, burnout, and

secondary traumatic stress. Interventions to support healthy work atmosphere and development of nurses' self-care strategies may aid in maintaining compassion and caring while promoting well-being. Leadership should incorporate practices that monitor signs and symptoms of compassion fatigue among nurses and provide resources for early interventions.

Recommendations

The integrative literature review by Sorenson et al. (2016) found that self-care was “reported to be the most significant preventative measure healthcare providers could take to protect themselves from CF” (p. 462). Continued research on the development of strategies for improving and sustaining a low level of compassion fatigue among nurses is needed. All nurses are at risk for compassion fatigue and little is known about the existence in medical-surgical nurses. More research is needed of compassion fatigue in medical-surgical nurses in different care settings to acquire a better understanding of its effects in order to establish strategies to decrease the risk. Educational opportunities should be readily available for nurses and nurses should feel free to discuss their concerns with their employers and leaders.

Conclusion

As shown through statistical analysis, compassion fatigue does not exist in medical-surgical nurses at the hospital being studied. There is no relationship between age and years of experience with compassion fatigue. However, there is a defined level of concern with nurses age 21-30 and two to five years of experience leaning towards the development of compassion fatigue. This study correlates with many other studies with older nurses having lower compassion fatigue scores. The literature review supports

compassion fatigue existing among nurses in a variety of healthcare settings such as, medical-surgical, emergency department, oncology, and critical care units. All nurses should be aware of signs and symptoms of compassion fatigue and have leadership support with resources for early intervention. This study had a moderate to high compassion satisfaction with all nurses. This study provides leadership good data to build on and put procedures into place to prevent compassion fatigue among medical-surgical nurses. Healthcare organizations would benefit from implementing nurse involvement with unit and organizational wide awareness of compassion fatigue and ways to combat the risk of nurses developing it.

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Appendix A

Professional Quality of Life Scale (ProQOL-5)

Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009) When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

- ___ 1. I am happy.
- ___ 2. I am preoccupied with more than one person I [help].
- ___ 3. I get satisfaction from being able to [help] people.
- ___ 4. I feel connected to others.
- ___ 5. I jump or am startled by unexpected sounds.
- ___ 6. I feel invigorated after working with those I [help].
- ___ 7. I find it difficult to separate my personal life from my life as a [helper].
- ___ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
- ___ 9. I think that I might have been affected by the traumatic stress of those I [help].
- ___ 10. I feel trapped by my job as a [helper].
- ___ 11. Because of my [helping], I have felt "on edge" about various things.
- ___ 12. I like my work as a [helper].
- ___ 13. I feel depressed because of the traumatic experiences of the people I [help].
- ___ 14. I feel as though I am experiencing the trauma of someone I have [helped].
- ___ 15. I have beliefs that sustain me.
- ___ 16. I am pleased with how I am able to keep up with [helping] techniques and protocols.

- ___17. I am the person I always wanted to be.
- ___18. My work makes me feel satisfied.
- ___19. I feel worn out because of my work as a [helper].
- ___20. I have happy thoughts and feelings about those I [help] and how I could help them.
- ___21. I feel overwhelmed because my case [work] load seems endless.
- ___22. I believe I can make a difference through my work.
- ___23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
- ___24. I am proud of what I can do to [help].
- ___25. As a result of my [helping], I have intrusive, frightening thoughts.
- ___26. I feel "bogged down" by the system.
- ___27. I have thoughts that I am a "success" as a [helper].
- ___28. I can't recall important parts of my work with trauma victims.
- ___29. I am a very caring person.
- ___30. I am happy that I chose to do this work.

© B. Hudnall Stamm, 2009. Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). /www.isu.edu/~bhstamm or www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.

Appendix B

Copy of Permission to use the ProQOL-5 Survey

The ProQOL measure may be freely copied and used, without individualized permission from the ProQOL office, as long as:

- (a) You credit The Center for Victims of Torture and provide a link to www.ProQOL.org;
- (b) It is not sold; and
- (c) No changes are made, other than creating or using a translation, and/or replacing "[helper]" with a more specific term such as "nurse."

Because you have agreed that your use of the ProQOL follows the above criteria, the ProQOL Office at the Center for Victims of Torture grants you permission to use the ProQOL. Your recorded request is attached here as a PDF.

If you have any questions or comments, you can contact us at proqol@cvt.org. Note that unfortunately our capacity is quite limited, as this is a volunteer-run effort, but we will do what we can to respond within a couple of weeks.

Thank you!

The ProQOL Office
at The Center for Victims of Torture
proqol@cvt.org

Appendix C

Informed Consent

Title of Study

Investigating Compassion Fatigue in Medical-Surgical Nurses

Researcher

Tammy Shepherd, BSN, RN, CMSRN

MSN Student, Gardner-Webb University, Hunt School of Nursing

Purpose

The purpose of this research is to explore the existence of compassion fatigue among medical-surgical registered nurses. Bedside nurses in acute care settings may be at a greater risk for experiencing emotional distress related to the long hours of direct patient care (Bao & Taliaferro, 2015). Ongoing stressful interactions with patients can initiate compassion fatigue and leave nurse to feel more obligated and less empathetic (Mattioli, Walters, & Cannon, 2018). “Compassion fatigue is defined as the loss of work related satisfaction, or when the job brings more distress than satisfaction” (Sheppard, 2015, p. 57), whereas nurses who are fully engaged and satisfied with their work are energetic and attain a considerable amount of gratification providing quality patient care (Sheppard, 2015).

Procedure

What you will do in the study:

In this study, you will complete a Professional Quality of Life Scale (ProQOL-5) survey via Office 365 forms that also asks two demographics questions. The survey seeks to answer the following research questions:

1. Does compassion fatigue exist in medical-surgical nurses?
2. Is there a relationship between age and years of nursing experience with compassion fatigue?

Time Required

It is anticipated that it will take approximately 15 minutes of your time to complete the survey.

Voluntary Participation

Participation in this study is voluntary. You have the right to not open or complete the anonymous survey.

Confidentiality

Data from the surveys will be completely anonymous and reported in aggregate form. Your name will not be collected at any time. After data collection, the survey and demographic responses will be password-protected. Once submitted, the researcher will not be able to withdraw responses due to anonymity and de-identified data.

Risks

While the research survey poses minimal risk there is a risk of loss of confidentiality to participants. There are no anticipated risks in this study.

Benefits

There are no direct benefits associated with participation in this study. The potential benefit from this research could improve nursing and leadership awareness of compassion fatigue and lead the way for future opportunity for interventions and management of compassion fatigue. The study has the possibility of paving a way for identifying future education needs for all nurses in the 540-bed system and could potentially provide awareness to compassion fatigue and generate a renewed sense of self care based on Jean Watson's Theory of Caring.

Payment

You will receive no payment for participating in the study.

Right to Withdraw From the Study

You have the right to withdraw from the study at any time before submitting the survey without penalty.

How to Withdraw From the Study

If you want to withdraw from the study, you may choose to skip any question, or stop at any time prior to submission by closing the browser window. The survey will close and data will not be saved once the browser window is closed.

If you have questions about the study, contact the following individuals

Tammy Shepherd, BSN, RN, CMSRN
Hunt School of Nursing
Gardner-Webb University
Boiling Springs, NC 28017
(864) 641-5978 tshepherd@gardner-webb.edu

Dr. Brittany Graham, EdD, MSN, RN
Hunt School of Nursing
Gardner-Webb University
Boiling Springs, NC 28017
(704) 406-2518 bgraham1@gardner-webb.edu

If you have concerns about your rights or how you are being treated, please contact the IRB Institutional Administrator listed below

Dr. Sydney K. Brown
IRB Institutional Administrator
Gardner-Webb University
Boiling Springs, NC 28017
Telephone: 704-406-3019 Email: skbrown@gardner-webb.edu

Office of Research Compliance
Institutional Review Board
101 East Wood Street
Spartanburg, SC 29303
864-560-6892 Email: researchcompliance@srhs.com

By clicking on the following link, you will be giving implied consent to participate in the survey:

https://forms.office.com/Pages/ResponsePage.aspx?id=pmeyOmQr802Gto5rgbiIU5cz3M0Z16xJh1h_2M-1ceFUOEVLVVpBSU5SS1NVM1VPS1VGUU5LVzRQM4u

Appendix D

E-Mail Sent to Participants with Informed Consent

Date: October 23, 2019

Subject: Investigating Compassion Fatigue in Medical-Surgical Nurses.

My name is Tammy Shepherd and I am in the graduate program at Gardner-Webb University Hunt School of Nursing, pursuing a Master of Science in Nursing (MSN) degree. My thesis title is "Investigating Compassion Fatigue in Medical Surgical Nurses." I am writing you to request your participation in a brief survey that is provided via a link to Office 365 forms at the end of the informed consent below. Medical-Surgical nurses have been chosen to participate in this 30-question survey to examine the existence of compassion fatigue. The Professional Quality of Life Scale-5 (PrpQol-5) survey will take approximately 15 minutes to complete and will explore the existence of compassion fatigue among medical surgical nurses. There will also be two demographic questions related to age range and years of nursing experience range which will be submitted with ProQOL-5 survey and stored in Office 365 forms in a password protected file that only the researcher has access to.

Your participation is completely voluntary, and all your responses will be kept confidential. No personally identifiable information will be associated with any reports of the data collected. While the research survey poses minimal risk there is a risk of loss of confidentiality to participants. There are no anticipated risks in this study.

The Spartanburg Regional Healthcare System (SRHS) Institutional Review Board (IRB) and the Gardner-Webb University IRBs have approved this study. Should you have any comments or questions, please feel free to contact me via e-mail at tshepherd@gardner-webb.edu or by phone 864-641-5978.

Your participation will be greatly appreciated and thank you for your time and cooperation!

Sincerely,

Tammy Shepherd BSN, RN, CMSRN

Gardner-Webb University MSN Student

Appendix E

Demographic Data Questionnaire

Demographic Data

Age (please check)

Age 21-30_____ Age 31-50_____ Age Greater than 50_____

Years of Nursing Experience (please check)

Less than 2 years_____ 2-5 years_____ 6-10 years_____ Greater than 10
years_____